

The Commonwealth of Massachusetts  
Bureau of Health Professions Licensure  
**Board of Registration in Dentistry**

250 Washington Street

Boston, MA 02108

(617) 973-0971

[www.mass.gov/dph/dentalboard](http://www.mass.gov/dph/dentalboard)

## **Facility Permit D-P**

(See 234 CMR 6.09 Effective August 20, 2010)

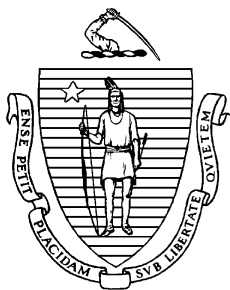
### **Requirements for the Use and Provision of Portable and/or Mobile Anesthesia Services**

#### **Application Instructions**

A qualified dentist anesthesiologist who travels to dental facilities or practice sites for the purpose of delivering anesthesia services or sedation services at the site must hold a Mobile Facility D-P Permit for the use of portable and/or mobile anesthesia equipment, supplies and personnel.

- The holder of a Facility Permit D-P shall:
  - (a) Comply with requirements of the Board pursuant to 234 CMR 5.05 and the reporting of adverse occurrences, pursuant to 234 CMR 6.17;
  - (b) Employ and provide immediate supervision of at least one dental or clinical auxiliary who is trained and qualified to assist in anesthesia administration and who is fully familiar with the procedures and protocols of the permit holder at each site where anesthesia is being administered by said permit holder;
  - (c) Schedule and perform maintenance checks of all equipment conducted by a certified equipment vendor at least once per year, and retain maintenance records for a minimum of three years;
  - (d) Conduct annual emergency drills for all staff involved in the administration of anesthesia, and retain records that describe the dates of the training activities, content of the training, and the attendance roster for a minimum of three years; and
  - (e) Place a copy of the anesthesia chart in the patient's dental record at the site where the anesthesia was administered.
- The Facility Permit D-P, or a copy thereof, shall be prominently displayed in the facility by the qualified dental anesthesiologist whenever and wherever he/she is providing anesthesia services.
- The operating dentist shall be responsible for verifying that the qualified dental anesthesiologist has the proper anesthesia permit and that the portable anesthesia service is appropriately permitted for the level of pain control and/or sedation to be provided.
- The qualified dental anesthesiologist shall be responsible for verifying that the operating dentist and his/her clinical staff maintain current certification in ACLS or BLS for Healthcare Providers, as applicable given the type of anesthesia being administered.
- There shall be a written and signed agreement between the Facility Permit D-P applicant and the operating dentist for each site where anesthesia is to be administered by the Facility Permit D-P holder which, at a minimum describes how emergency response training and protocols will be developed and practiced, procedures for verifying qualifications of personnel who assist in the care and monitoring of the patient, responsibilities for pre- and post- operative patient assessment and monitoring, responsibilities for obtaining informed consent, and how compliance with applicable board statutes and regulations will be achieved and maintained at the site.

**DO NOT SUBMIT THIS APPLICATION UNLESS ALL EQUIPMENT IS INSTALLED, CALIBRATED, AND  
READY FOR INSPECTION**



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**Application –Facility Permit D-P**

1. APPLICANT NAME \_\_\_\_\_ MA DN Lic. # \_\_\_\_\_  
Last First MI

2. BUSINESS ADDRESS: \_\_\_\_\_  
No. Street Unit #  
\_\_\_\_\_  
City/Town State Zip Code

3. BUSINESS NAME/DOING BUSINESS AS: \_\_\_\_\_

4. TELEPHONE NUMBER-DAY: \_\_\_\_\_ CELL: \_\_\_\_\_ FAX: \_\_\_\_\_

5. EMAIL ADDRESS: \_\_\_\_\_

6. **PRACTICE OWNER** (if different from applicant)

Name: \_\_\_\_\_ MA Dental Lic. # \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

7. **TYPES OF ANESTHESIA TO BE ADMINISTERED (check all that apply):**

- ☐ Nitrous Oxide- Oxygen Only  
☐ Nitrous Oxide-Oxygen + Oral Sedatives  
☐ Oral Sedation Only  
☐ I.V. Sedation  
☐ General Anesthesia and Deep Sedation  
☐ Other route of administration:

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## **FACILITY PERMIT D-P APPLICATION ATTACHMENTS**

- ☐ **Attachment 1:** Personal or business check or money order made payable to THE COMMONWEALTH OF MASSACHUSETTS in the amount of \$180. **All fees are nonrefundable and nontransferable.**
- ☐ **Attachment 2:** Required Equipment and Emergency Drugs (**see form attached**)
- ☐ **Attachment 3:** Copy of current ACLS or PALS or BLS certificates for all individuals administering or assisting with anesthesia
- ☐ **Attachment 4:** Copy of medical history form.
- ☐ **Attachment 5:** Copy of anesthesia chart form.
- ☐ **Attachment 6:** Copy of anesthesia consent form.
- ☐ **Attachment 7:** Copy of a schedule and log demonstrating the regular inspection of all emergency drugs and equipment for administration of anesthesia, including the date(s) and name of person who last checked drugs and equipment and the results of the checks, including that of the condition of equipment according to manufacturers' specifications.
- ☐ **Attachment 8:** Copy of a written protocol for management of emergencies.
- ☐ **Attachment 9:** Copy of schedule and content of regular and routine emergency drills.
- ☐ **Attachment 10:** Copy of Federal DEA Controlled Substance Certificate and MA Controlled Substance Registration. (M.G.L. c. 94C, §10)
- ☐ **Attachment 11:** Request for on-site inspection by the Board
- ☐ **Attachment 12:** Copy of all current individual anesthesia permits of staff.

**APPLICANT ATTESTATION:** I \_\_\_\_\_ **HEREBY CERTIFY,**  
Print Full Name of Applicant  
**UNDER THE PAINS AND PENALTIES OF PERJURY, THAT:**

- **ALL INFORMATION PROVIDED IN THIS APPLICATION IS ACCURATE AND TRUE;**
- **I HAVE READ AND UNDERSTOOD THE STANDARDS AND REQUIREMENTS FOR THE ADMINISTRATION OF ANESTHESIA AND SEDATION AS PROMULGATED BY THE BOARD ON AUGUST 20, 2010 AT 234.CMR 6.00, INCLUDING, BUT NOT LIMITED TO, THE REQUIREMENTS OF THIS PERMIT FOR:**
  - **AUXILIARY PERSONNEL REQUIRED**
  - **PATIENT EVALUATION REQUIRED**
  - **PRE-OPERATIVE PREPARATION REQUIRED**
  - **PATIENT MONITORING AND DOCUMENTATION REQUIRED**
  - **MANAGEMENT OF RECOVERY AND DISCHARGE OF PATIENTS**
  - **MANAGEMENT OF PEDIATRIC AND SPECIAL NEEDS PATIENTS**
  - **EMERGENCY MANAGEMENT**
  - **CURRENT ACLS, PALS AND BLS CERTIFICATION FOR ALL STAFF ADMINISTERING AND ASSISTING**
- **I UNDERSTAND THAT, UNDER THE TERMS OF THIS PERMIT, THE ADMINISTRATION OF GENERAL ANESTHESIA, DEEP, MODERATE, AND MINIMAL CONSCIOUS SEDATION AND NITROUS OXIDE-OXYGEN SEDATION IS LIMITED SOLELY TO THE PRACTICE SITE WHERE THERE IS THE REQUISITE FACILITY PERMIT OR LICENSE FOR THE TYPE OF ANESTHESIA OR SEDATION TO BE ADMINISTERED.**
- **I AM CURRENTLY, AND WILL CONTINUE TO BE, IN COMPLIANCE WITH ALL STATUTES, RULES, AND REGULATIONS PERTAINING TO THE PRACTICE OF DENTISTRY IN THE COMMONWEALTH OF MASSACHUSETTS AS REQUIRED BY LAW.**

**SIGNATURE OF APPLICANT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**APPLICATION VALID FOR ONLY 90 UPON RECEIPT.**

## ATTACHMENT 2 (Page 1)

### EQUIPMENT REQUIRED BY 234 CMR 6.00, AS APPLICABLE.

EQUIPMENT REQUIRED	DATE LAST INSPECTED
Alternative light source for use during power failure	
Ambu-bag or portable bag-mask ventilator	
Automated or manual external defibrillator, including batteries and other components	
Disposable CPR mask (pediatric and adult)	
Disposable syringes (assorted sizes)	
Endotracheal tubes with inflatable cuffs and other equipment designed to maintain patient airway including: <ul style="list-style-type: none"> <li>Pediatric endotracheal tubes, assorted sizes.</li> <li>Adult endotracheal tubes, assorted sizes</li> <li>Connectors from tubes to gas delivery machines</li> <li>Syringe for cuff inflation</li> <li>Stylet</li> </ul>	
Endotracheal tube forceps	
Equipment for emergency crico-thyroidectomy and/or tracheostomy with appropriate connectors to deliver 100% oxygen and establish emergency airway	
Equipment for the insertion and maintenance of an intravenous infusion	
Equipment suitable for proper positioning of the patient for administration of cardiopulmonary resuscitation, including a back board	
Equipment for continuous monitoring during anesthesia	
Gas delivery system capable of positive pressure ventilation, which must include: <ul style="list-style-type: none"> <li>Oxygen</li> <li>Safety-keyed hose attachments</li> <li>Capability to administer 100% oxygen in all rooms (operatory, recovery, examination, and reception)</li> <li>Gas storage in compliance with safety codes</li> <li>Adequate waste gas scavenging system</li> <li>Nasal hood or cannula.</li> </ul>	
Laryngoscope (straight and/or curved blades, assorted sizes; extra batteries and bulbs)	
Latex free tourniquet	
List of emergency telephone numbers clearly visible	
Magill forceps or other suitable instruments	
Means of monitoring blood pressure (pediatric and adult)	
Means of monitoring heart rate and rhythm, with battery pack back-up	
Means of monitoring respirations	
Means of monitoring temperature	
Means of transporting patients	
Method to accurately record elapsed time	
Nasopharyngeal airways (pediatric and adult)	
Oropharyngeal airways (pediatric and adult)	
Oxygen (portable Cylinder E tank) pediatric and adult masks capable of giving positive pressure ventilation including bag-valve-mask system	
Scavenger system, if inhalation agents are used	
Sphygmomanometer and stethoscope (pediatric and adult)	
Suction: <ul style="list-style-type: none"> <li>Suction catheter for endotracheal tube</li> <li>Tonsillar suction tip</li> <li>Suction equipment for use during power failure</li> <li>Capability of suction in all operatories and recovery rooms.</li> </ul>	
Schedule and log for checking and recording dates when anesthesia accessories and supply of emergency drugs have been checked	
If nitrous oxide and oxygen delivery equipment capable of delivering less than 25% oxygen is used, an in-line oxygen analyzer must be used	

## ATTACHMENT 2 (Page 2)

### EMERGENCY DRUGS AND DRUG CLASSIFICATIONS REQUIRED, AS APPLICABLE.

REQUIRED DRUGS	NAME OF DRUG	DOSAGE	EXPIRATION DATE
Acetylsalicylic acid (rapidly absorbable form)			
Ammonia inhalants			
Anticonvulsant			
Antihistamine			
Antihypoglycemic agent			
Antihypertensive medications			
Antiemetic			
Atropine			
Bronchodilator			
Corticosteroid			
Dantrolene Sodium (required if a halogenated anesthesia agent <i>e.g.</i> halothane, enflurane, isoflurane is used or depolarizing skeletal muscle relaxants <i>e.g.</i> succinylcholine are administered)			
Epinephrine pre-loaded syringes and ampules (pediatric and adult)			
Lidocaine			
Intravenous antihypoglycemic agent (dextrose 50% or glucagon)			
Medication to treat supraventricular tachycardia ( <i>e.g.</i> adenosine, verapamil, etc.)			
Muscle relaxants			
Narcotic antagonist and reversing agents			
Oxygen			
Sodium bicarbonate			
Succinylcholine			
Vasodilator			
Vasopressor			

**Attachment 2 (page 3)**

<b>NAME OF DENTIST/ANESTHESIOLOGIST WHO WILL BE ADMINISTERING ANESTHESIA</b>	<b>LICENSE NUMBER</b>	<b>ANESTHESIA PERMIT NUMBER</b>	<b>ACLS/PALS/BLS CERTIFICATION EXPIRATION DATE</b>

<b>NAME(S) OF DENTAL/SURGICAL ASSISTANT(S)</b>	<b>LICENSE NUMBER</b>	<b>CPR/BLS CERTIFICATION EXPIRATION DATE</b>

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**SIGN AND SEND THIS APPLICATION AND ALL REQUIRED ATTACHMENTS TO:**

**BUREAU OF HEALTH PROFESSIONS LICENSURE**

**BOARD OF REGISTRATION IN DENTISTRY**

**250 WASHINGTON ST., BOSTON, MA 02108**

**KEEP A COPY OF THIS APPLICATION AND ALL ATTACHMENTS FOR YOUR RECORDS**

**INCOMPLETE APPLICATIONS WILL BE RETURNED.**